

## **Clinical Guidelines for Enteral Nutrition**

These Guidelines identify the clinical information that the Rhode Island Medical Assistance Program requires to determine medical necessity for Enteral Nutrition products. The Guidelines are based on generally accepted standards of medical practice, review of medical literature, federal and state policies, and laws applicable to Medicaid programs.

Enteral Nutrition is defined as supplemental feeding provided via the gastrointestinal tract orally, or through a tube, catheter or stoma distal to the mouth.

## **Clinical Coverage**

Determination of medical necessity for enteral products shall be based upon a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the product, including but not limited to:

1. Enteral Nutrition, whether orally or by tube feeding, is used as a therapeutic regimen to prevent serious disability or death in a person with a medically diagnosed condition that precludes the full use of regular food.
2. The person presents clinical signs and symptoms of impaired digestion malabsorption, or nutritional risk, as indicated by the following anthropometric measures:  
Weight Loss that presents actual or potential for developing malnutrition as follows:
  - (a) In adults:
    - i. involuntary or acute weight loss equal to or greater than 10% of usual body weight over a three to six month period or a Body Mass Index (BMI) below 18.5.
  - (b) In neonates, infants, and children showing:
    - i. very low birth weight (less than 1500 grams) even in the absence of gastrointestinal, pulmonary, or cardiac disorders;
    - ii. lack of weight gain or weight loss to a value less than two standard deviations below the age appropriate mean in one month for children under age six months or in two months for children aged six to twelve months;
    - iii. no weight gain or abnormally slow weight gain for three months for children older than one year; or
    - iv. weight for height less than the tenth percentile, abnormal laboratory tests pertinent to the diagnosis and risk factors for actual or potential malnutrition have been identified and documented.

3. Enteral Nutrition is indicated as the primary source of nutritional support; i.e., is essential for the management of factors that impair digestion or cause malabsorption, for surgical preparation, or postoperative care.
4. A written plan of care has been developed for regular monitoring of signs and symptoms to detect improvement in the person's condition. Nutritional status should be monitored regularly.
5. Diagnosis of inborn errors of metabolism that require medically necessary formula used for specific metabolic conditions such as (but not limited to): Phenylketonuria (PKU), homocystinuria, maple syrup urine disease, propionic aciduria and methylmalonic aciduria.

**6. Non-coverage**

1. Enteral Nutrition products shall not be considered medically necessary under certain circumstances including but not limited to, the following:
  - (a) A medical history and physical examination have been performed and other alternatives comparable in effect and available to the member that are more conservative or less costly to RI Medicaid have been identified to minimize nutritional risk;
  - (b) The person is underweight but has ability to meet nutritional needs through the use of regular food consumption;
  - (c) Enteral products are used for a weight loss or dieting program;
  - (d) The presence of food allergies, lactose intolerance, or dental problems when nutritional requirements may be met through an alternative food source comparable in effect and available to the member; or
  - (e) Enteral products used as supplements to a normal or regular diet in a person showing no clinical indicators of nutritional risk.
  - (f) No medical history or physical examination has been taken and/or there is no documentation to RI Medicaid that supports the need for enteral nutrition products.

2. Requests for Enteral Nutrition for lack of appetite or cognitive problems will be denied.

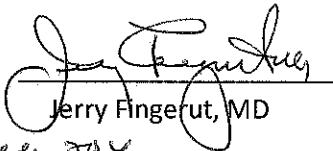
3. Compounding of Enteral Nutrition products is a non-covered service.

**Submitting clinical documentation and Prior Authorization request:**

Prior authorization will be required and determinations made on a case by case basis. Approval of prior authorization is still subject to all general conditions of Rhode Island Medicaid including member eligibility, other insurance and program restrictions.

1. Requests for prior authorization must be accompanied by clinical documentation, including a recent history and physical examination which supports medical necessity for the requested product.
2. Documentation must also include a complete Rhode Island Medical Necessity Review Form including, but not limited to, specific data for requested calories and units of product per day, number of monthly refills, and duration of need. Divide the number of calories per day by 100, (e.g., 100 calories equals 1 unit) and multiply that number by the number of days for treatment. This equals total units.
3. Prior authorization shall be valid for 12 months from date of issuance. All change in treatment must be documented in writing and a new prior authorization is required.
4. For Medicaid-enrolled children also enrolled in WIC, Medicaid will be the primary payor for enteral nutrition products when such products are medically necessary and are covered by the Medicaid State Plan.

Approved by:

  
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Associate Medical Director

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Reviewed: \_\_\_\_\_

Revised: \_\_\_\_\_